Union Security Life Insurance Company of New York

Administrative Office
P.O. Box 977122, Miami, FL 33197-7122 • 1.877.438.7085 • Fax 305.252.6910
Attn: DFS Claims Department

DISABILITY CLAIM FORM

All benefit payments are paid directly to your creditor, and will be shown on your monthly billing statement.

IMPORTANT NOTICE
PLEASE READ CAREFULLY BEFORE COMPLETING YOUR CLAIM FORM

Failure to complete required sections and/or provide requested documentation will delay processing of your claim.

INSTRUCTIONS FOR COMPLETING FORM

If the needed sections are not complete or if the attachments are not attached, the processing of the claim will be delayed. (Check box after each item is completed.)

AFTER 30 CONSECUTIVE DAYS OF DISABILITY (Example: Disabled 01/01/2011, complete form after 02/01/2011).

☐ **1. Complete Section 1.**
- ☐ **If you are receiving Social Security Disability, please provide us with a copy of your award letter or verification that you are receiving SSDI.**
- ☐ **If you are self-employed attach a copy of your business license.**
- ☐ **Attach a copy of your <u>ENTIRE</u> CREDIT CARD BILLING STATEMENT (including the top portion) for the month in which your disability started.**

☐ **2. Have your doctor complete Section 2.**

- To avoid late fees, continue to make your payments until you receive notification that your claim has been approved.
- If your claim is approved, a continuing claim form must be submitted every 30 days for additional payments to be made.

Fax completed form and all supporting documentation to 305.252.6910 or mail to:
DFS Claims Department
PO Box 977122
Miami FL 33197-7122

<u>ONCE YOUR CLAIM IS RECEIVED</u>

- **YOU WILL RECEIVE A LETTER ACKNOWLEDGING RECEIPT OF YOUR CLAIM. THE LETTER WILL CONTAIN YOUR CLAIM NUMBER.**
- **PLEASE ALLOW 15 BUSINESS DAYS FOR YOUR CLAIM TO BE PROCESSED.**
- **AFTER YOUR CLAIM HAS BEEN PROCESSED, YOU WILL RECEIVE A LETTER ADVISING OF APPROVAL, DENIAL OR REQUEST FOR ADDITIONAL INFORMATION.**

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SECTION 1 - CARDHOLDER'S INFORMATION **PLEASE PRINT**

NAME OF FINANCIAL INSTITUTION OR STORE THAT ISSUED CREDIT CARD	CREDIT CARD - ACCOUNT NUMBER

NAME OF PRIMARY CARDHOLDER	DATE OF BIRTH	PLACE OF EMPLOYMENT	HOURS WORKED PER WEEK
	/ /		

NAME OF CLAIMANT	DATE OF BIRTH	PLACE OF EMPLOYMENT	HOURS WORKED PER WEEK
	/ /		

CLAIMANT'S JOB TITLE	DATE HIRED
	/ /

TYPE OF EMPLOYMENT	LAST DAY YOU WORKED	DATE YOU RETURNED TO WORK
☐ Full Time ☐ Part Time ☐ Seasonal ☐ Temporary ☐ Self-Employed	/ /	/ /

HAVE YOU RESUMED DUTIES	NUMBER OF HOURS PER WEEK
☐ Yes ☐ No If yes, ☐ Full Time ☐ Part Time	

ARE YOU RETIRED	IF YES, DATE RETIRED	REASON FOR INTERRUPTION OF EMPLOYMENT OR RETIREMENT
☐ Yes ☐ No	/ /	

CLAIMANT'S STREET ADDRESS/APT. #	CITY	STATE	ZIP CODE

TELEPHONE NUMBER (DAY)	TELEPHONE NUMBER (EVENING)	CLAIMANT'S EMAIL ADDRESS (IF AVAILABLE)
( )	( )	

I AUTHORIZE any employer, physician, hospital, clinic, other medical or medically related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsuring company, insurer, law enforcement agency, fire department, Social Security Administration, Internal Revenue Service, or other organization, or person having any records, data, or information concerning this claim to furnish such record, data, or information to the insurance company issuing my policy. I understand that in executing this authorization, I waive the right for such information to be privileged as it pertains to the processing or investigation of my claim(s). A photocopy of this authorization shall be considered as effective and valid as the original.

I understand and acknowledge that this authorization extends to all or any part of the records being requested, which may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis and treatment. I expressly consent to the release of information as designated above.

The above information is true and correct. If, in fact, the furnished information is false, thereby inducing payment of claim, and the insurance company issuing my policy determines that the incorrect information constitutes an aiding and abetting the filing of a fraudulent claim, the insurance company issuing my policy may furnish the above information to the appropriate state authorities to be used in its discretion as the basis for action authorized under applicable state law. In addition, I agree any statements made on this or any other form found to be false shall give the insurance company issuing my policy the right to void my policy.

I, or my authorized representative, have the right to receive a copy of this authorization.

This authorization shall remain valid for the duration of the claim.

WARNING: *Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

CLAIMANT'S SIGNATURE	CLAIMANT'S SOCIAL SECURITY NUMBER	DATE
X	- -	/ /

SECTION 2 - DOCTOR'S STATEMENT

PLEASE PRINT

(to be furnished without expense to the Insurance Company)

PATIENT'S FULL NAME	DIAGNOSIS (CODE(S))
	☐ ICD-9_____ ☐ CPT_____ ☐ DSM III_____

CURRENT DIAGNOSIS

LIST THE NAMES OF ALL PRESCRIBED MEDICATIONS FOR THIS DIAGNOSIS

GIVE EXACT DATES OF TOTAL DISABILITY (UNABLE TO WORK)	**GIVE EXACT DATES OF PARTIAL DISABILITY**
FROM / / TO / / ☐ His/Her Occupation ☐ Any Occupation	FROM / / TO / / ☐ His/Her Occupation ☐ Any Occupation

IN YOUR EXPERT OPINION, HOW WOULD YOU QUALIFY THIS PATIENT	IF TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED
☐ Permanently Disabled ☐ Temporarily Disabled ☐ Non-Disabled	☐ 1-2 months ☐ 3 months ☐ 6 months ☐ Longer than 9 months ☐ Undetermined

PHYSICAL IMPAIRMENTS (AS DEFINED IN FEDERAL DICTIONARY OF OCCUPATIONAL TITLE)

☐ Class 1 - No limitation of functional capacity; capable of heavy work; no restrictions. (0-10%)

☐ Class 2 - Medium manual activity. (15-30%)

☐ Class 3 - Slight limitation of functional capacity; capable of light work. (35-55%)

☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%)

☐ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary) activity. (75-100%)

IS CONDITION DUE TO PREGNANCY	IF YES, DESCRIBE COMPLICATIONS	ESTIMATED DATE OF DELIVERY
☐ Yes ☐ No		/ /

WHEN DID SYMPTOMS FIRST APPEAR	WAS DISABILITY CAUSED BY AN ACCIDENT	IF YES, DATE OF ORIGINAL ACCIDENT
/ /	☐ Yes ☐ No	/ /

IF YES, DESCRIBE ACCIDENT

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION	GIVE DATES OF TREATMENT FOR SIMILAR CONDITION (MM/DD/YY)
☐ Yes ☐ No	

DESCRIBE SAME OR SIMILAR CONDITION

GIVE NAMES, ADDRESSES, AND PHONE NUMBERS OF OTHER TREATING PHYSICIANS (ATTACH ADDITIONAL SHEET IF NECESSARY)

DATES OF TREATMENT	FREQUENCY OF VISITS
FIRST VISIT / / LAST VISIT / / NEXT VISIT / /	☐ Weekly ☐ Monthly ☐ Other (specify)_____

HAS PATIENT BEEN HOSPITALIZED	NAME OF HOSPITAL
☐ Yes ☐ No If yes, FROM / / THROUGH / /	

STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER
				( )

DID PATIENT HAVE SURGERY	IF YES, DESCRIBE SURGERY	DATE PERFORMED
☐ Yes ☐ No		/ /

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION	**IF PATIENT IS STILL UNDER YOUR CARE, GIVE ESTIMATED DATE WHEN PATIENT WILL RESUME WORK**	IF NOT, GIVE DATE PATIENT WAS RELEASED TO RESUME WORK
☐ Yes ☐ No	/ /	/ /

PROGNOSIS/COMMENTS (HAS PATIENT PROGRESSED)

"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER	FAX NUMBER
				( )	( )

ATTENDING PHYSICIAN'S NAME (PLEASE PRINT)	ATTENDING PHYSICIAN'S SIGNATURE	MEDICAL ID NUMBER	DEGREE	DATE
	X			/ /

FORM MUST BE FULLY COMPLETED AND SIGNED OR STAMPED BY DOCTOR'S OFFICE